MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF SURVEILLANCE

POLIOMYELITIS REPORT

				CASE NO.
PATIENT	NAME (LAST, FIRST, M.I.)			COUNTY
	ADDRESS	CITY	STATE	ZIP CODE
Reporting Physician Nurse/Hosp/ Clinic	NAME			TELEPHONE
	ADDRESS	CITY		ZIP CODE

DEMOGRAPHICS

BIRTHDATE (MONTH/DAY/YEAR)

SEX
☐ MALE ☐ FEMALE ☐ UNKNOWN

RACE
☐ NATIVE AMER./ALASKAN NATIVE ☐ WHITE
☐ ASIAN/PACIFIC ISLANDER ☐ OTHER
☐ AFRICAN AMERICAN ☐ UNKNOWN

ETHNICITY
☐ HISPANIC
☐ NOT HISPANIC
☐ UNKNOWN

CLINICAL DATA

DATE OF FIRST SYMPTOMS

PRELIMINARY DIAGNOSIS
☐ NONPARALYTIC POLIO
☐ PARALYTIC POLIO

TYPE OF PARALYSIS
☐ BULBAR
☐ SPINAL
☐ BULBO-SPINAL

CLINICAL DESCRIPTION OF ILLNESS (DATES, COURSE, ETC.)

LABORATORY - STATE LABORATORY

SPECIMENS FOR ISOLATION SUBMITTED
☐ YES ☐ NO

SPECIMEN TYPE	DATE OBTAINED	RESULT (TYPE)

SERUM SPECIMENS SUBMITTED
☐ YES ☐ NO

	TEST (NEUT. CF)	DATE OBTAINED	P1	P2	P3
SERUM 1					
SERUM 2					
SERUM 3					

CSF DATA	DATE	#WBC	% LYMPH	PROT	GLU
CSF 1					
CSF 2					
CSF 3					

LABORATORY - CDC LABORATORY

SPECIMENS FOR ISOLATION SENT	RECEIVED	DATE RECEIVED
☐ YES ☐ NO	☐ YES ☐ NO	

SPECIMEN TYPE	DATE OBTAINED	RESULT (TYPE)

STRAIN CHARACTERIZATION RESULTS
☐ VAN WEZEL ☐ OLIGONUCLEOTIDE

SERUM SPECIMENS SUBMITTED	RECEIVED	DATE(S) RECEIVED
☐ YES ☐ NO	☐ YES ☐ NO	

	TEST (NEUT.)	DATE OBTAINED	P1	P2	P3
SERUM 1					
SERUM 2					
SERUM 3					

EMG	NERVE CONDUCT

IMMUNOLOGIC STATUS

KNOWN IMMUNE DEFICIENCY ☐ YES ☐ NO	DESCRIBE
IMMUNE STUDIES ☐ YES ☐ NO	WHICH

RESULTS

VACCINE HISTORY

INACTIVATED VACCINE (SALK) ☐ NOT VACCINATED		ORAL VACCINATION (SABIN) ☐ NOT VACCINATED	
DOSE	DATE OF VACCINATION	TYPE OF VIRUS	DATE OF VACCINATION
1		TYPE 1	
2		TYPE II	
3		TYPE III	
4		TRIVALENT	

IF SALK INOCULATION WITHIN 30 DAYS PRIOR TO ONSET		IF ORAL VACCINATION WITHIN 30 DAYS PRIOR TO ONSET	
MFR	LOT NO.	MFR	LOT NO.
SITE OF INJECTION	SITE(S) OF 1ST PARALYSIS	HOUSEHOLD OR CLOSE CONTACT WITH ORAL VACCINE WITHIN PREVIOUS 60 DAYS ☐ YES ☐ NO	

EXPOSURE HISTORY

CASE/HH MEMBER TRAVEL TO ENDEMIC/EPIDEMIC AREA ☐ YES ☐ NO	WHO	WHERE	DATE(S)
CASE/HH MEMBER EXPOSURE TO PERSON(S) FROM OR RETURNING FROM ENDEMIC AREAS ☐ YES ☐ NO	WHO	WHERE	DATE(S)
CASE/HH CONTACT WITH KNOWN CASE ☐ YES ☐ NO	WHO	WHERE	DATE(S)
OPV RECIPIENT CONTACT ☐ YES ☐ NO			
HOUSEHOLD CONTACT ☐ YES ☐ NO	DATE	AGE	RELATION
NON-HOUSEHOLD CONTACT ☐ YES ☐ NO	DATE	AGE	
DATE CONTACT RECEIVED OPV	DOSE NUMBER	LOT NUMBER	

FOLLOW UP

CLINICAL STATUS 60 DAYS OR LONGER AFTER ONSET

- ☐ COMPLETE RECOVERY, NO RESIDUAL PARALYSIS
- ☐ MINOR INVOLVEMENT ONLY
- ☐ SIGNIFICANT DISABILITY
- ☐ SEVERELY DISABLED (BED, WHEELCHAIR, EXTENSIVE BRACING)
- ☐ DEATH - DATE _____
- CAUSE OF DEATH _____
- ☐ NEVER ANY PARALYSIS (NONPARALYTIC)

FINAL CLASSIFICATION

- ☐ PARALYTIC POLIO WITH RESIDUAL PARALYSIS
- ☐ PARALYTIC POLIO, NO RESIDUAL PARALYSIS
- ☐ PARALYTIC DISEASE DUE TO OTHER AGENT
  SPECIFY _____

ASEPTIC MENINGITIS DUE TO:

- ☐ POLIOVIRUS (NONPARALYTIC POLIO)
- ☐ ECHO
- ☐ COXSACKIE
- ☐ OTHER (SPECIFY) _____
- ☐ ASEPTIC MENINGITIS, UNKNOWN ETIOLOGY
- ☐ OTHER FINAL DIAGNOSIS _____

INSTRUCTIONS

Please submit this form immediately after preliminary information has been obtained on a suspected case of poliomyelitis.

Subsequently, revised copies of this form should be submitted when additional information becomes available. The following information, usually obtained in epidemiologic investigations of poliomyelitis cases, should be included: (attach additional sheet if necessary).

a. Clinical History: A brief narrative of history, physical signs, and clinical laboratory result, including peripheral white blood cell count and cerebrospinal fluid findings.

b. Travel History: An itinerary of the patient's travel outside of city of residence during preceding 30 days; history of contact with travelers.

c. Poliovaccine Contact History: Household or other close contact with a recipient of oral poliovaccine within 60 days prior to onset of illness; specify date and relationship of recipient; if recipient is not a household member, describe frequency of contact and dates of contact. Include available virologic data on contacts of patient.

d. Other: Describe other recent or concurrent immunizations. For young infants, history of breast feeding and maternal history of vaccination or exposure to poliomyelitis should be described.

DATE CASE FIRST REPORTED TO STATE MONTH DAY YEAR	FORM COMPLETED BY	TELEPHONE ( )	DATE FORM COMPLETED MONTH DAY YEAR